MOUNT RAINIER COUNCIL BOY SCOUTS OF AMERICA

INELIGIBLE VOLUNTEER RECORD SHEET

REGISTRATION SERVICE

BOY SCOUTS OF AMERICA

COUNCIL NO. 612 DATE 7-3-90

FULL NAME: EDGAR A. TISDALE

SOCIAL SECURITY NUMBER: [redacted]

ADDRESS: [redacted]

CITY: TACOMA STATE: WASH. ZIP CODE: 98498

DATE OF BIRTH 12-28-53

RELIGION: L.D.S. NATIONALITY: U.S.A.

OCCUPATION: STAFF SPECIALIST-MEDICAL EDUCATION:

WEIGHT: 185 lbs. HEIGHT: 6'1" RACE: CAUCASIAN

COLOR OF HAIR: BROWN COLOR OF EYES: UNKNOWN

OUTSTANDING CHARACTERISTICS OR INTERESTS:

MARRIED OR SINGLE: MARRIED CHLDREN: UNKNOWN

SPOUSE'S NAME: [redacted]

SCOUTING CONNECTIONS: CHARTERED ORGANIZATION: LDS CHURCH

UNIT: 480 CITY: TACOMA STATE: WASH.

POSITION: MERIT BADGE/COMMISSIONER DATE REGISTERED: 2/7/89

DATE RESIGNED: SPECIAL RECOGNITION:

SUSPENDED OR DENIED REGISTRATION FOR FOLLOWING REASON:

STATEMENT FROM PARENT INDICATING CHILD MOLESTATION OF HER SON BY ED TISDALE

SIGNED: [signature] 7-5-90
Scout Executive

COUNCIL: MOUNT RAINIER

CONFIDENTIAL

JUL 10 1990

F. STARON

CONF019491

TRAN CNCL P/UNIT STATUS EXP-DATE TERM TRANSFER--FROM ERROR MESSAGE
TRAN CNCL P/UNIT MEMB # NAME ADDRESS CITY STATE ZIP
STATUS POS/RNK ADULT/YOUTH MBR-TERM TRANSFER--FROM CNCL P/UNIT MBR-ID / TO CNCL P/UNIT MBR-ID
ERROR MESSAGE

200 6
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202 6
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202 6

BOY SCOUTS OF AMERICA
MEMBERSHIP SUPPORT SYSTEM
INELIGIBLE VOLUNTEER CHECKING MATCH REPORT - VAN

	MEMBER KEY	LAST NAME	FIRST NAME	MIDDLE NAME	SEX	BIRTH YEAR	SOC SEC NO
CONT		FOWLER	RICHARD		M	42	000-00-0000
	612S0480 044616	STEVENS	D CHRIS		M	00	[redacted]
		STEFFEN	GARY	LEE	M	51	
		STEFFEN	LEE	GARY	M	51	
		STEPHENS	BRIAN	NEIL	M	00	
		STEPHENS	CHARLES	E	M	47	
		STEPHENS	RICHARD	CHRISTOPHER	M	38	
		STEPHENSON	STEVE		M	27	
		STEVENS	BERT	H	M	32	
		STEVENS	GARY	JAMES	M	60	
		STEVENS	LOU	L	M	28	
		STEVENSON	E	J	M	44	
	612S0480 049028	STONE	WILLIAM S		M	60	
		STEIN	MICHAEL	DAVID	M	58	
	612S0480 049029	PETERSON	RICHARD A		M	50	
		PETERS	MATHEW		M	00	
		PETERSEN	ERIC	D	M	48	
		PETERSON	JAMES	HOWARD	M	45	
		PETERSON	STEVE	C	M	49	
		POTTER JR	GENE	R	M	49	
	612S0480 059989	TISDALE	EDGAR A		M	53	
		TISDALE	EDGAR	A	M	53	
	612S0482 058229	DAVIES	KIRK L		M	62	
		DAVIS	MARK	W	M	63	
		DAVIS	SAMUEL	D	M	62	
		DEBOSE	MICHAEL	R	M	65	
	612S0482 058233	COCO	IRENE K		F	59	
		CHASE	ELLEN		F	57	
	612S0482 064480	SCHNEBLY	M JAMES		M	37	
		SCHOONOVER	JOHN	EDWARD	M	36	
	612S0482 064483	GEORGE	BARTON K		M	60	
		GEHRKE	MERLIN	LYNN	M	58	
		GROSS	THOMAS	C	M	63	
	612S0482 064484	JOHNSON	THOMAS		M	55	
		JENKINS	HOWARD	ASHLEY	M	57	
		JOHNSON	CHARLES	EDWARD	M	59	
		JOHNSON	DANIEL	BRUCE	M	60	
		JOHNSON	RICHARD		M	53	
		JOHNSON	WILLARD	L	M	53	
		JOHNSON	WILLIAM	H	M	50	
		JUNKIN	DOUGLAS	REX	M	51	
	612S0482 064486	LEWIS	LAURENCE		M	59	
		LACY	RUPERT	H	M	58	
		LAGOS	DWIGHT	ALLEN	M	57	
		LAKS	DON		M	00	
		LEWIS	DAVEY		M	57	

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T242 _ TSHLICKIS         MICHAEL                     32  M  [redacted]
T250 _ TEZON             PETER        E              52  M
T252 _ TUSING            CLIFTON      RUSSELL        40  M
T260 _ TUCKER            JAMES                       36  M
T265 _ TSCHORN           HENRY                       51  M

  PFKEYS: 1-HELP 3-CHANGE 4-ADD 7-PREV 8-NEXT 10-DELETE ENTE
MS04                           MEMBERSHIP SUPPORT SYSTEM              10/29/90
                                 MEMBER DETAIL INQUIRE                07:55:14
 CNCL 612  PRG/UNIT S0480 SEQ. 059989
 FIRST: EDGAR A                  LAST : TISDALE
 ADDR1: [redacted]               ADDR2: TACOMA            WA
 ADDR3:                          ADDR4:                        ZIP: 98498
 REG STATUS: N  ENROLL: 0890 BIRTH: 1253 SEX: M  AGENCY: M ADULT/YOUTH: A
 POSITION:  MC  FINDERCODE: 52  PHONE: [redacted]  BULK:    MAG-STATUS:
 REN DAT: 0191
 TRANSFER FROM = CNCL:     PGM/UNIT:        SEQ:         TRANSFER DATE:
                                  MAGAZINES
         --SOURCE-- PRICE SUB STRT --COPIES-- ISSUES TO GO AREAR  LAST LABEL EXP
   TYPE  CNCL P/UNT CODE  TRM DATE FIRST LAST ORIG  TOTAL COUNT  PRINTED   DAT
    S    ___  ____   N    03  1090  1090 1190  01    001   00      0929   0191
    _    ___  ____   _    __  ____             __          __
    _    ___  ____   _    __  ____             __          __
ENTER>CHG  PF1>NEXT  PF10>PRT  PF11>PREV  PF12>MENU  CLR>END  PF6>VAN OVERRIDE
NEXT CNCL:      P/U:        SEQ:        LST: TISDALE        FST: EDGAR A
```

8-30-90
9-20-90
10-1-90

10-29-90
Norm Stone S.E.
Ltr was sent reinstating
Tisdale by Council. Probation
will register or S.E. indicating
of write to
concern.

[illegible signature]

Clyde LeCompte

COUNCIL 612

TRANSMISSION 000901

P-UNIT TRN OP TRAN CTR ----------DISPOSITION MESSAGE----------

[redacted]

TIME: 17:34:33 TRANSMISSION DISPOSITION LOG PAGE 1602

COUNCIL 612

TRANSMISSI 00901

P-UNIT TRN TRAN

MOUNT RAINIER COUNCIL
BOY SCOUTS OF AMERICA

SCOUTING/USA

FOR ALL BOYS IN PIERCE AND SOUTH KING COUNTIES
1722 SO. UNION AVE. TACOMA. WASHINGTON 98405

COUNCIL NO. 612
206-752-7731

July 5, 1990

PAUL ERNST
Registration Service S108
National Council
Boy Scouts of America
1325 Walnut Hill Lane
P. O. Box 152079
Irving, Texas 75015-2079

FOR EVERY 100 BOYS WHO JOIN SCOUTING.

- 2 WILL BECOME EAGLE SCOUTS
- RARELY WILL ONE BE BROUGHT BEFORE JUVENILE COURT
- 12 WILL HAVE THEIR FIRST CONTACT WITH A CHURCH
- 1 WILL ENTER THE CLERGY
- 18 WILL DEVELOP HOBBIES THAT [illegible] LAST THROUGH THEIR LIFE
- 5 WILL EARN THEIR CHURCH AWARD
- 8 WILL ENTER A VOCATION THAT WAS LEARNED THROUGH THE MERIT BADGE SYSTEM
- 1 WILL USE HIS SCOUTING SKILLS TO SAVE A LIFE
- 1 WILL USE HIS SCOUTING SKILLS TO SAVE HIS OWN LIFE
- 17 WILL BE FUTURE SCOUT VOLUNTEERS.

Dear Paul,

Here is the information regarding EDGAR TISDALE and the alleged child molestation at our Camp Hahobas in 1989.

As per my discussion with our Regional Director, Richard Harrington, we will issue a letter denying registration, explain that we will hold a local inquiry and allow Edgar Tisdale to appeal, if he so requests to a local council committee.

Sincerely,

NORMAN J. STONE
Scout Executive

NJS:blm
cc/Richard Harrington

7-13-90 - Call from Norm Stone, S.E. - Council Review Held 7-12-90. Letter to Reinstate in Process - Pending

MOUNT RAINIER COUNCIL [redacted] BOY [redacted]OUTS OF AMERICA

SUSPECTED CHILD ABUSE REPORTING FORM

MOUNT RAINIER COUNCIL

BOY SCOUTS OF AMERICA

THE FOLLOWING INFORMATION WAS PROVIDED TO:

PAUL ERNST

NATIONAL OFFICE

NAME OF SUSPECTED ABUSER: EDGAR A TISDALE

ADDRESS: [redacted], TACOMA, WA 98498

TELEPHONE NO.: Home [redacted] Business [redacted]

SCOUTING POSITION IF KNOWN: UNIT COMMISSIONER AND CAMP STAFF

CHILD'S NAME: [redacted] DATE OF BIRTH:

ADDRESS: [redacted], KENT, WA 98032

PARENT'S NAME: [redacted]

ADDRESS: [redacted] KENT WA 98032

TELEPHONE NO: [redacted]

PHYSICAL INDICATORS OBSERVED: TIRED LOOK (ACCORDING TO [redacted])

BEHAVIORAL INDICATORS OBSERVED: ANXIETY, HYPERVENTILATION, RESTLESNESS.

OTHER INDICATORS OBSERVED/KNOWN:

REPORTER'S NAME AND POSITION: NORMAN J. STONE , SCOUT EXECUTIVE

DATE OF REPORT: 7-5-90 SIGNATURE:

MOUNT RAINIER COUNCIL BOY SCOUTS OF AMERICA

NOTES ON CONVERSATION:

FRANK H. ERICKSON with [redacted], mother of [redacted] on whose behalf an insurance claim was submitted as a result of alleged incident at Hahobas, 1989.

[redacted] said that the family had discussed with DR. ALLAN UNIS, a Psychiatrist at Children's Orthopedic Hospital, the possibility of the boys symptoms being a result of inhaling cutter's insecticide and then sleeping in a tight, confined area. The doctor said it might be possible, but did not make a diagnosis.

[redacted] said that [redacted] still has problems, identified as: Loss of short-term memory and "recurrence of previous problems".

She said she has not heard from our insurance carrier (Rhulen Agency for AIG Life) on any settlement.

Their primary insurer is King County Medical Blue Shield. Only covers up to $2,000.00 psychiatric costs.

Indicated that they are suing King County as they live near the Midway Land Fill, which emits methane gas.

THE MOTHER'S HISTORY OF EVENT AT HAHOBAS:

Boy had trouble Thursday morning, came home Saturday, when she saw his physical condition (rings around eyes, looking thin), she called an ambulance and sent him to the hospital. No one has been able to diagnose the problem. The boy thinks "Dr. Ed" (Ed Tisdale, the Camp Medic) rubbed his penis and slept with him.

(Sheriff of Mason County investigated and found no evidence. [redacted] says doctor's and lawyer don't believe the boy was molested, because "he doesn't act like it.")

The boy hallucinates once in awhile, not often anymore.

MEDICATION: Haloperidol, has been reduced to 1/2 mg.

FHE:blm
6/6/90

ACTIONS OF NORMAN J. STONE

[redacted] MATTER

6/20/90 Conversation with [redacted].

1. Her son made claim of molestation on two occasions during stays at Children's Orthopedic Hospital sometime between July 29, 1989 to August 15, 1989 and September 6, 1989 to September 28, 1989.

2. A report was made to Child Protective Services August 8, 1989. Because it was a Third Party Claim, Child Protective Services did not investigate, but referred the matter to the Mason County Sheriff's Department. Sheriff Crane talked to the family on November 3, 1989.

3. I placed a call to Gary Crane ([redacted], the Mason County Investigating Office. No return call.

4. [redacted] says Dr. Allan Unis of Children's Orthopedic Hospital said "her son did not act like he was molested".

6/22/90 9:00 A.M. - Called Sheriff Crane again. Left message.

6/25/90 Sheriff Gary Crane returned call. He verified that the case was dropped due to lack of evidence. He investigated Ed Tisdale. Sheriff Crane said Ed Tisdale was straight forward with him during the investigation. The Sheriff did not pursue the matter. Said, "Investigation was inconclusive".

6/26/90 Talked to Paul Ernst - Reported matter and discussed option.

6/28/90 Called Richard Harrington. Left message. Harrington returned call, I was not in.

7/02/90 Discussed case with George Leonhard. He said "he did not know of molestation incident".

7/03/90 Call to Harold Frizell's office to learn disposition of liability claim. None on file. Deborah Duhs to return call.

7/03/90 Called Harrington again.

7/03/90 Talked to Richard Harrington. Decided on course of action.

1. Deliver letter revoking membership.
2. Tell Tisdale we will continue to conduct local inquiry.
3. If requested, we will conduct local review/appeal.
4. I will send cover letter to Paul Ernst with details.

7/03/90 Confirmed above conversation with Paul Ernst. Paul agreed to proceedure.

7/03/90 Talked with Dr. Allan Unis, Psychologist at Children's Orthopedic Hospital, who treated [redacted].

1. Dr. Unis has "no clear sense that anything happened".
2. "All the kids at camp were discussing about people being gay".
3. "All I have is open ended theory".
4. "To this day, I do not have a cause for [redacted] presentation".
5. After final release [redacted] "did very well", was taken off medication, did very well for six months but had a reoccurance after another camping trip.
6. The best intent for the child is that I would be able to talk with Ed Tisdale, the medic.
7. Currently, I have "at least the suspicion that something occured - [redacted] action made it a possibility, no matter how unlikely.
8. Dr. Unis stated "he does not know whether [redacted] has a chronic continuing condition or one which was brought on by a specific incident". (Paraphrased).

NJS:blm
7/5/90

Sent Copy to Mason County Sherrif Sept 27, 89

Sent [redacted] to Boy Scout Camp July 23, 1989 - July 29, 1989. Wed. he went swimming got real cold couldn't get warm. Went on Wilderness camp Wed. night with two other boys. Thurs. morning he was real tired and began to deteriate from then on. Wanted to call home Bill Johnson & Mr. Hilderbrant wouldn't let ~~him~~ him. Friday he was seen by (Dr. Ed Lisdale)? Army medic. They brought him home Sat. around 1:00. We took him to St Frances Hospital from Bill Johnson house. He acted like he was about 4 yrs old. Transferred him to Childrens in Seattle about 9:00 P.M.

He talked about his heart hurting and he was afraid he was going to die. Talked about Dr. Ed rubbing his Penis. He was saying all kinds of crazy things. He was like this till Aug 8, 1989. He was ~~did~~ discharged on Aug 15th 89.

spend the night with Dr. Ed.

Send copy to Mason County Sheriff.

On Sunday Sept 3, 1989 he started acting strange. Called Dr. Uries at Childrens. He called in a prescription for Haldol. We took him back to the hospital Wed Sept 6th. He was mixed up until Thurs. the 14th of Sept That night he told my husband ([redacted] and me our son ([redacted]) that Dr. Ed was rubbing his leg and kept bumping his penis. My Son ([redacted]) ask him if it bothered him and [redacted] said yes it did. He also had drawn a picture of two stick men laying side by side with a line going to the others ~~Crotch~~ crotch. He said he slept with Dr. Ed. [redacted] will have to be on Haldol for 6 months to a year. We don't know what kind of a future he will have. The doctors Dr. John Wiley and Dr. Uries said they don't know ~~what~~ what is wrong with him. All of the tests have come back normal. [redacted] won't tell us anymore now that he is back to normal. [redacted] was released as an [illegible] 9-

[redacted] He said [redacted] ask Mr. Johnson and Mr. Hildabro and they told him it cost to much money.

[redacted] left for camp July 23, 1989. When at Camp he went on a wilderness over night Camp on wed Thursday morning Bill Johnson (Scott master) said, [redacted] said he was real tired. Bill said it was slow deterioration. noon he thought [redacted] was going to be able to sleep so he left him in the tent to sleep. Came back around 3:00 found him up at the Trading post sitting on a bench. Bill said he was rambling. That night [redacted] slept in Bills tent and Bill slept on the Picnic table.

Friday morning Bill said he seemed a little better. Around 4:00 Dr. Ed Lisdale (medic from army was called. Dr. calmed him down a little bit. Eating habits were real strange. Richard Hildebrant stayed at Camps. Between 9:00 & 9:30 they couldn't get him to sleep.

(2)

[redacted] wanted a shower, so he took a shower. 10:00 10:30 Behavior no different.

Saturday 12:30 or so I received a call from Bills wife ([redacted], she said the boys should be home in about 20 min and [redacted] wasn't sleeping very well the last couple nights. I went to pick him up at Bills house and he was in thier sons bed. I took one look at him and said, get me a ambulance. He acted like he was 4 or 5 years old. We took him to St Frances in Federal Way. about 1:00 or 1:30 P.M. We were transfered to Childrens at 9:00 or 9:30 P.M. He was in Childrens from July 29th to Aug 15th. He was home 3 weeks and 1 day.

He started getting sick Sunday Sept 3rd called the Doctor monday and he ended up back at Childrens Sept 6th (wed) with the same symptoms. He is still there. [redacted] behavior was a little strange He loved everyone. Wanted hugs + kiss

(3)

[redacted] was real concerned about [redacted] & I. He kept asking if we were alright. He would ask us and then he would say, "are you sure you're alright?

On Sun. Sept 14th we went to the Hospital, [redacted] was out ~~play~~ playing a game. We walked up and he seemed to be almost normal. We went to his room and he wanted me to rub his back. While doing this I told him if there was anything he wanted to tell us no matter what we would still love him. He said Dr. Ed was rubbing his legs and kept bumping his penis. [redacted] ask him if it bothered him, [redacted] said "yes it did". He had drawn to stick men laying side by side with a line going to the others ~~Crotch~~ crotch. That was the last time it was mentioned. [redacted] seemed to improve more every day. We were ~~of~~ able to bring

him home on a pass on Sunday 9-24-8 Slept alot during the day. On Wed the 27th of Sept they gave us a pass and we brought him home for the night [redacted] was so happy to be home. He was affraid to sleep up in his room He slept on the couch 8:00 a.m. till 8:00 a.m. Took him back to the hospital and they released him to come home. [redacted] slept all the way home from Childrens and laid on the couch and slept 1½ hrs. He has been real tired. Went to bed at 8:00 P.M. Thurs.

Friday woke up at 8:00 A.M. took his meds back to bed slept till 9:30. Not very active, did walk to store. Eat lunch 12:00 back to sleep at 12:30 didn't wake up till 3:00 P.M. He rode his bike and played a little soccer with the neighbor kids. That night he did some situps he seemed a little hyper, but glad he got some exercise. Was tired by 9:00 and asleep by 9:15.

to me [redacted]

Bill Johnson said the boys were talking about gays. He gave them a long lecture on the gay population

Bills wife said one of the boy scouts was talking about cutting out your heart. ~~and boring~~ with an axe.

MOUNT RAINIER COUNCIL
BOY SCOUTS OF AMERICA

SCOUTING/USA

FOR ALL BOYS IN PIERCE AND SOUTH KING COUNTIES
1722 SO. UNION AVE. TACOMA, WASHINGTON 98405
COUNCIL NO. 612
206-752-7731

July 5, 1990

EDGAR TISDALE
[redacted]
Tacoma, WA 98498

Dear Mr. Tisdale,

After careful review, we have decided that your registration with the Boy Scouts of America should be denied. We are therefore compelled to request that you sever any relations that you have have with the Boy Scouts of America.

You should understand that BSA membership registration is a privilege and is not automatically granted to everyone who applies. We reserve the right to refuse registration whenever there is a concern that an individual may not meet the high standards of membership which the BSA seeks to provide for American youth.

If you wish to have this decision reviewed by a Mount Rainier Council review committee, please write to the Scout Executive within 60 days of the date of this letter, explaining your version of the facts supporting your claim that your registration as a BSA member should be reinstated. The procedures for a review of this decision are attached.

Sincerely yours,

NORMAN J. STONE
Scout Executive

NJS:blm
Enclosure

FOR EVERY 100 BOYS
WHO JOIN SCOUTING.

2 WILL BECOME EAGLE SCOUTS

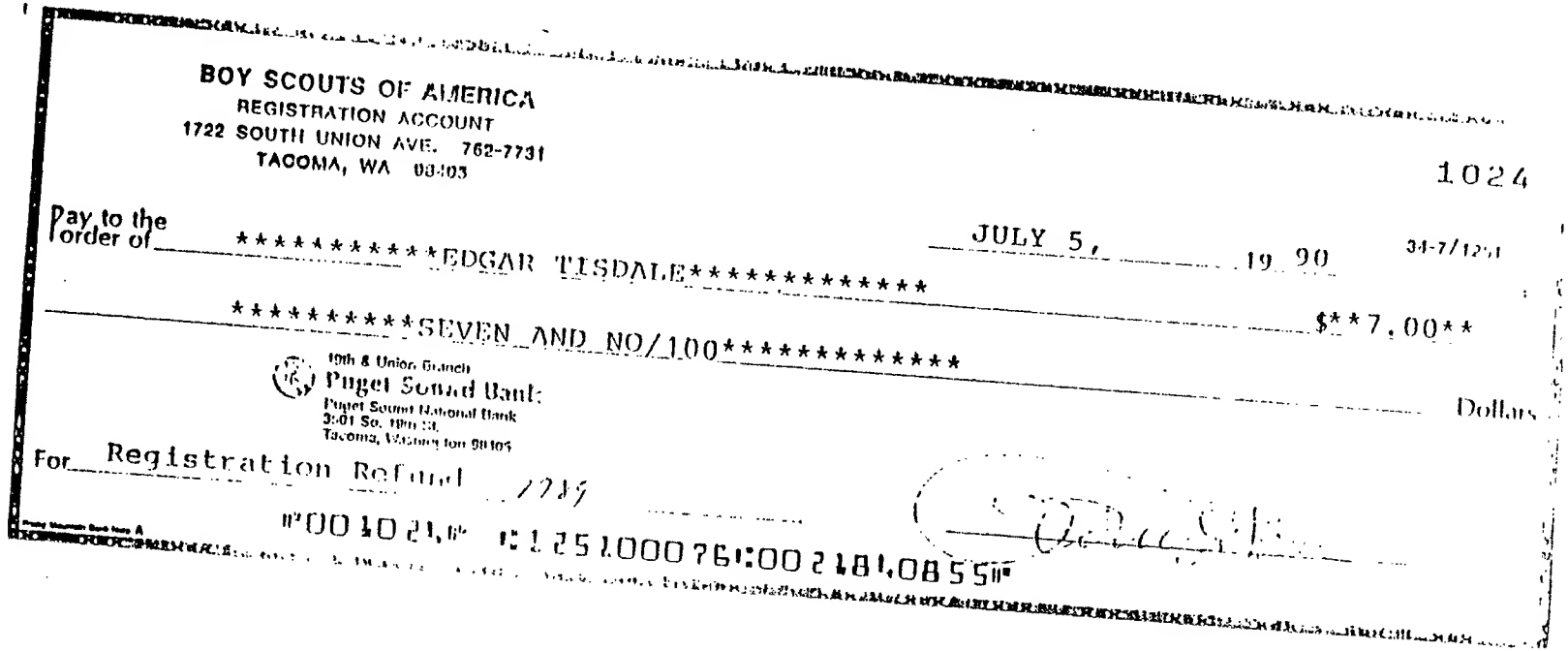
1 WILL BE BROUGHT BEFORE A JUVENILE COURT

1 WILL EARN THE MERIT BADGE MEDAL

1 WILL USE HIS SCOUTING SKILLS TO SAVE A LIFE

1 WILL USE HIS SCOUTING SKILLS TO SAVE HIS OWN LIFE

17 WILL BE FUTURE SCOUT VOLUNTEERS.



BOY SCOUTS OF AMERICA
REGISTRATION ACCOUNT
1722 SOUTH UNION AVE. 762-7731
TACOMA, WA 98405

1024

Pay to the order of **********EDGAR TISDALE**********

JULY 5, 19 90

34-7/1251

**********SEVEN AND NO/100********** $**7.00**

Dollars

19th & Union Branch
Puget Sound Bank
Puget Sound National Bank
3501 So. 19th St.
Tacoma, Washington 98405

For Registration Refund 1225

⑈001024⑈ ⑆125100076⑆00218108550⑈

MOUNT RAINIER COUNCIL
BOY SCOUTS OF AMERICA

SCOUTING/USA

FOR ALL BOYS IN PIERCE AND SOUTH KING COUNTIES
1722 SO. UNION AVE. TACOMA, WASHINGTON 98405
COUNCIL NO 612
206-752-7731

July 5, 1990

RHULEN AGENCY
[redacted]
Monticello, N.Y. 12701

Dear Sirs:

Please let me know the disposition of this claim. I have not found any followup in our files, and the Mother, [redacted], has complained about not hearing from your agency.

Thank you for your assistance.

Sincerely,

NORMAN J. STONE
Scout Executive

NJS:blm
Enclosure

FOR EVERY 100 BOYS WHO JOIN SCOUTING,

- 2 WILL BECOME EAGLE SCOUTS
- RARELY WILL ONE BE BROUGHT BEFORE JUVENILE COURT
- 12 WILL HAVE THEIR FIRST CONTACT WITH A CHURCH
- 1 WILL ENTER THE CLERGY
- [illegible] DEVELOP HOBBIES THAT [illegible]T THROUGH THEIR [illegible]E
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- 17 WILL BE FUTURE SCOUT VOLUNTEERS.

CONF019510

MEDICAL CLAIM REPORT

AIGLIFE

A member company of
AMERICAN INTERNATIONAL GROUP
One Alico Plaza, Wilmington, DE 19899

Administered by: **RHULEN AGENCY**
217 Broadway
Monticello, N.Y. 12701
Recreation & Sports Medical

PLEASE MAIL CLAIM FORM TO ABOVE ADDRESS.

[redacted]

INSTRUCTIONS: 1. Fully itemized bills for medical expenses should be attached.
2. Forward two copies and retain one copy for file.
3. **THIS FORM MUST BE SENT WITHIN 20 DAYS AFTER INCEPTION OF CLAIM.**
4. **BILLS MUST BE FURNISHED WITHIN 90 DAYS.**

NAME OF CAMP: Camp Hahobas	LOCATION OF CAMP: Belfair WA		POLICY NUMBER: 6700000 ID NUMBER:
NAME OF CLAIMANT: [redacted]	☒ MALE ☐ FEMALE	DATE OF BIRTH: [redacted]	NAME AND ADDRESS OF PARENT (IF CLAIMANT IS A MINOR) OR CLAIMANT: [redacted]
CITY: Kent	STATE: WA	ZIP: 98032	PHONE NO.: [redacted]
CAMP OPENING DATE: June 25	CAMP CLOSING DATE: Aug 13	DATE CAMPER ARRIVED: July 23	DATE [illegible] IF STILL IN ATTENDANCE, DATE SCHEDULED TO LEAVE: July 29
DATE AND HOUR OF ACCIDENT OR SICKNESS: July 27 PM	NATURE OF INJURY OR SICKNESS: Unknown sickness		IS THIS A PRE-EXISTING CONDITION? YES ☐ NO ☐ IS THIS A CHRONIC CONDITION? YES ☐ NO ☐ Unknown
HOW AND WHERE DID ACCIDENT OCCUR? (ACCIDENT CLAIMS ONLY): Unknown			
WAS CLAIMANT ON CAMP PREMISES AT THE TIME OF THE CLAIM? (ACCIDENT CLAIMS ONLY) YES ☒ NO ☐	WAS CLAIMANT INVOLVED IN A SPONSORED CAMP ACTIVITY AT THE TIME OF THE CLAIM? YES ☒ NO ☐ (ACCIDENT CLAIM ONLY)		TO WHOM SHOULD PAYMENT BE MADE? ☒ CAMP ☐ PARENT ☐ HOSPITAL ☐ DOCTOR ☐ OTHER (PLEASE SPECIFY)
DOES CLAIMANT HAVE OTHER INSURANCE? YES ☒ NO ☐ IF YES, NAME & ADDRESS OF COMPANY: Blue Shield			

AUTHORIZATION

You are authorized to give the AIG Life Insurance Company or its authorized representative information regarding my, or any family member's medical history, physical condition, and diagnosis. A photostat of this authorization shall be valid as the original. This authorization will be valid for the term of my coverage under the policy.

SIGNED (Authorized Camp Representative)	TITLE	DATE	SIGNED (Parent, if Claimant is a Minor; or Claimant)	DATE
[redacted]	Administrator	10-29-89		

ATTENDING PHYSCIAN'S STATEMENT — To be completed for all claims exceeding $50.00 (Type or Print)

PATIENT'S NAME (First name, middle initial, last name) | PATIENT'S DATE OF BIRTH

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) | DATE FIRST CONSULTED YOU FOR THIS CONDITION | HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐ IS THIS A CHRONIC OR RECURRING CONDITION? YES ☐ NO ☐

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office) | WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES:

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3,ETC. OR DX CODE

1. 3.
2. 4.

A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (CPT)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES

SIGNATURE OF PHYSICIAN OR SUPPLIER	ACCEPT ASSIGNMENT YES ☐ NO ☐	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
SIGNED DATE	YOUR SOCIAL SECURITY NO.	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
YOUR PATIENT'S ACCOUNT NO	YOUR EMPLOYER I.D. NO	I.D. NO.		

#3613-B (8/87)

W-5072-7/89-15M

DAILY FIRST AID LOG

All entries should be made in ink.

Time (24:00)	Print Name Last	First	Unit Number	Complaint/Type of Accident
1700	[redacted]		237	Anxiety, Can't sleep, Hyperventilat

DATE: 2[redacted] / [illegible] / 18
Day Month Year

Comments (Activity and Location)	Treatment/Disposition	Treated by
	[redacted]	

MASON COUNTY

SHERIFF'S OFFICE
Sheriff Bob Holter

MASON COUNTY COURTHOUSE
P.O. BOX 1037
SHELTON, WA 98584

SHELTON 427-9670
BELFAIR 275-4467
1-800-562-5628

September 29, 1989 Case No. 89-6945-1

Director
Boy Scouts of America
Rainier Council
[redacted]
Tacoma, WA 98402

Dear Sir,

The Mason County Sheriff's Office received a referral from Childrens Protective Services in Kent, Washington, reference a [redacted], date of birth [redacted]

[redacted], a member of the Boy Scouts, reportedly was at Hahobas Scout Camp in Mason County the week of July 23 through 29, 1989. According to the CPS referral, [redacted] reported being molested by a camp staff member.

I am requesting any documentation you may have regarding this allegation and your assistance in resolving this matter.

If you have any questions or concerns, please call Monday through Friday, 8:30 a.m. to 4:00 p.m. Thank you in advance for your attention to this matter.

Sincerely,

Gary J. Crane
Detective

jea

ESIS
An HRA Corporation Company

LIABILITY ACCIDENT NOTICE

BOY SCOUTS OF AMERICA	CONTRACT # 835	INSURANCE COMPANY OF NORTH AMERICA

COUNCIL

Name: Mt Rainier Council
Phone: [redacted]
Address: [redacted]
Location Code: 1 | 2 | 3

TIME & PLACE

Date and Time of Accident: ( ) AM ( ) PM
Location: Camp Hahobas
Council or Unit Activity? Cncl Summer Camp

INJURED PERSON

Name: [redacted]
Age: 14
Address: [redacted]
Home Phone: [redacted]
Business Phone:
Occupation or Scout Status: Boy Scout
Employed By:

THE INJURY

Nature & Extent of Injury:
Where Was Injured Taken After Accident?
Name of Doctor:

PROPERTY DAMAGE

Owner:
Home Phone:
Business Phone:
Address:
Estimated Cost of Repair:
List Damage:

DESCRIPTION OF ACCIDENT

ADULT LEADERS/ WITNESSES

Name	Address	Phone

UNIT SPONSOR

OTHER INSURANCE

Were Mutual of Omaha benefits paid?

9/27/89
DATE

SIGNATURE OF COUNCIL REPRESENTATIVE

WHITE COPY TO LOCAL ESIS OFFICE
CANARY COPY TO RISK MANAGEMENT SERVICE (SUM 402) AT THE NATIONAL OFFICE
PINK COPY FOR LOCAL COUNCIL FILE

Form ES-5216

CONF019515

7/27

Tupper to mother last week phone call
Ed Tisdale - Medic touched
turned over to CPS. - cleared (no grounds

Illness limits $750 camp ins.

call supervisor

INA
send ES 15/report sigma
Bellevue 98009
C-90026
PO 1-881-3700

Capone

Wed act weird
bed early

Thurs afternoon
~~saying things that didn't~~
acting up
night ~~that~~ kept others up

Friday afternoon
took to Medic
checked out

stayed up w 2 adults til about 3 Fri.
slept in chair until 4 AM

Sat went home w troop

in Hosp 17 days
back in again

11:25 a.m. 9-26-89

Margery Tedrick, Atty

[redacted]

John Tupper said to send bills to Scouts - she wants to know who will pay - if BSA doesn't, they may have to sue!

She said she is not investigating criminal actions at this time.

She called back 9/27. She called her back 9/27. Told her claim forms in

Mr. Leonhard's
9-27-89 11:50
Harold Flegel
Risk Management
National

JH

secondary to any other ...

Marjorie Tedrick Atty called 9/2[redacted]
told her to send us bills
boy back in hosp
she wouldn't be the atty but is helping

9/27 I called Tedrick
She said bills sent here via mail this mo
Tupper said forms in yesterday.

[redacted]

King Co. Med. Examiner

Hypothermia

Please call

R

4/11/90

T. 237

[redacted] call leader on medication

[redacted]

15 yr. old

[redacted]

AMER. INTERNATIONAL GROUP

claim form

John never called back

Hosp end Sept

Child Protection

U.W. Physical

$16,000 balance after insurance

upto $2,000

$200 deducts,

4 30 5 Friday after Tahopla

T. P. Paul Hendrix Commissioner

+2 adults

Anxiety hyper vent

resp chi

no sleep

mumbling if fell asleep

Paper bag

stop hyper vent

Paul back w him to camp

to dinner

skips campfire

Butler

was cold call doctor

diabetic measure blood glucose

glucometer normal

called Dr back anxiety attack

(boy afraid to go home)

Tupper talked to [redacted] of dying adult

beer at home talked about dru

afraid of something

Paul + SM + him went to health

cold

Benedril Recom by Dr.

nat to campfire
boy at troop site
to health lodge
shower
grab on to arm
friends used drugs
off on hypervent, drink water,

3:30 dozed off for 1 hr. awake each time
all dozed off & on
by morning calmed down
seemed to regress in age
couldn't do for self
shower w clothes on
vital signs normal

Jerry has book, trunk, cardboard file cabi

Dr - no need to send home
dymentia Psychosis? - Seattle Hosp.

tumor on gums said
cut away & back again in 1 week
lady down street died cancer

Smthing some of time

[redacted]

Gary Crane
det, Sheriff

[redacted]

elbow rub Francis Trusdale

12/28/53

Ed Tisdale

D-604

Madigan Hosp

[redacted]

Ft Lewis
98433

Hi: [redacted]
W:

Myrt

584-4575

Wimer & Harpold
Attorneys at Law

(206) 251-6093
8009 South 180th, Suite 108 • Kent, Washington 98032

October 26, 1989

Mr. John Tupper
Boy Scouts of America
[redacted]
Tacoma, WA 98405

Re: Client/Claimant: [redacted]
Incident: Arose Out of Boy Scout Camp Attendance July 23, 1989 - July 29, 1989

Dear Mr. Tupper:

Please find enclosed herewith additional medical bills incurred by [redacted] which medical invoices are in addition to and supplemental to those prior submitted to you by attorney Marjorie G. Tedrick in her letter of September 27, 1989.

Please note that this office has become associated, in regard to this matter, with Ms. Tedrick's law firm and, as such, all correspondence relating to the above-referenced matter should be sent to the undersigned.

Your prompt attention in regard to processing the enclosed invoices would be greatly appreciated. In doing so, please note that some of these have been independently paid by or through the boy's parents, [redacted] and, as such, remittance for the medical invoices submitted herewith and prior submitted to you should be made payable to [redacted] and sent to this office.

Sincerely yours,

Stephen K. Harpold

SKH/mjm

Enclosures

Law Offices
HARPOLD, FORNABAI & FIORI, P.C.
3204 AUBURN WAY NORTH
AUBURN, WASHINGTON 98002

AUBURN (206) 833-5001
SEATTLE (206) 838-0510
TACOMA (206) 924-0124
FACSIMILE (206) 735-4935

DAVID L. HARPOLD
KENNETH W. FORNABAI
JACK H. LEININGER
MARJORIE G. TEDRICK

Real Estate Escrow
JULIE A. CHRISTENSON, LPO/LA

Legal Assistants
ANN ROWLEY
SUE LOVELL
ART HUSMANN

September 27, 1989

Mr. John Tupper
Boy Scouts of America
[redacted]
Tacoma, WA 98405

Re: [redacted]

Dear Mr. Tupper:

Please find enclosed the medical bills accrued during [redacted] first hospitalization directly after his return from Camp Hahobas on July 29, 1989.

[redacted] has currently been hospitalized again at Children's Orthopedic in Seattle for the past twenty-one days. We will send those bills along as soon as we have them compiled.

For your information, this office has contacted the Mason County Sheriff to initiate an investigation into the events at Camp Hahobas during [redacted] stay there. I suggest you conduct an internal investigation also. Certainly there are a great many unanswered questions.

Sincerely,

HARPOLD, FORNABAI & FIORI, P.C.

Marjorie G. Tedrick

MGT:mt
Enclosures
cc: Mr. and Mrs. Dennis Capponi

STATEMENT

► 2

	97C	C01	[redacted]	0385665
/20/89	97C	C01	[redacted]	S6872
	09/18/89			

[redacted]

KENT, WA

98032

FOR PROPER CREDIT PLEASE R[redacted]

0841	I	08/11/89	310.1	8662	PSYCHOTHERAPY	33.00
0250	I	08/12/89	310.1	8662	2 DAYS HOSP VISIT/EXAM LIMIT	106.00
0847	I	08/14/89	310.1	8549	FAMILY THERAPY	106.00
0841	I	08/14/89	310.1	8549	PSYCHOTHERAPY	33.00
0853	I	08/15/89	310.1	8549	GROUP THERAPY	45.00

RETAIN THIS STATEMENT FOR TAX PURPOSES

09/18/89

NOTICE SEE REVERSE FOR IMPORTANT INFORMATION

► [redacted]

► [redacted]

SUBSCRIBER'S

[redacted]

CHILDREN'S ASSOCIATED CLINICIANS

[redacted]

2,636.00

CONF019529

STATEMENT

1

	97C 001 I	[redacted]	C385665
/20/89	97C 001 C		96872
	C9/18/89		

[redacted]

KENT, WA

98032

IMPORTANT

FOR PROPER CREDIT PLEASE R[illegible]

PREVIOUS BALANCE 1,042.00

C385665 [redacted]

				DENTAL	
9310	O	08/04/89	959.9	8559 CONSULTATION	40.00
				EMERGENCY ROOM	
515	O	07/29/89	977.9	8734 INTERMEDIATE SERVICE	65.00
				CONSULTATION LIAISON:INPATIENT	
0605	I	08/02/89	298.8	8086 INTERM CONSULT LIAISON INPT	150.00
				INPATIENT MEDICINE	
0620	I	08/02/89	310.9	8309 COMPREHEN CONSULTATION	168.00
0620	I	08/02/89	780.0	8309 COMPREHEN CONSULTATION	168.00
0605	I	08/03/89	780.0	8309 INTERMED CONSULTATION	97.00
0610	I	08/04/89	310.9	8309 EXTENSIVE CONSULTATION	126.00
				BEHAVIORAL SCIENCE	
0801	I	08/09/89	310.1	8662 DIAGNOSTIC INTERVIEW/WORK-UP	99.00
0220	I	08/09/89	310.1	8662 COMPREHENSIVE INITIAL EXAM	168.00
0280	I	08/10/89	310.1	8549 1 DAYS HOSP VISIT/EXAM COMPR	137.00
0843	I	08/10/89	310.1	8662 PSYCHOTHERAPY	53.00

RETAIN THIS STATEMENT FOR TAX PURPOSES

C9/18/89

NOTICE SEE REVERSE FOR IMPORTANT INF[illegible]

MAIL ► [redacted]

NUMBER ►

[redacted]

XT

SEATTLE, WASHINGTON 98145-5065 PHONE (206) 543-3600
TAX I.D. NO. [redacted]

DATE	SOC. SEC. NO.	PRIMARY	SECONDARY	M.D.	PATIENT NAME	ACCOUNT NUMBER
/28/89	[redacted]	970	001	0	[redacted]	[redacted]

PLEASE RETURN AFTER 09/25/89 FOR CURRENT MONTH'S STATEMENT

PLEASE INDICATE AMOUNT ENCLOSED

26975510

[redacted]
KENT, WA
98032

MAKE CHECKS PAYABLE TO: UNIVERSITY PHYSICIANS
VISA/MASTERCARD ACCEPTED - SEE REVERSE SIDE

IMPORTANT

Payment of these charges is your responsibility. This bill is for Physician Services only. Charges appearing on this statement are not included on any Hospital bill or statement. Payment of the balance shown is due and payable within 30 days unless prior payment terms have been arranged. See reverse side for more information.

FOR PROPER CREDIT PLEASE RETURN THIS PORTION OF YOUR STATEMENT

LOCATION	MOD	SERVICE DATE	DIAG	CPT	DESCRIPTION	AMOUNT
					PREVIOUS BALANCE	.00
0552	0	9/11/89	R225.	7470	MAGNETIC RESONANCE IMAGING MRI-BRAIN INTERMEDIATE	249.00

RETAIN THIS PORTION FOR TAX PURPOSES

PAYMENTS RECEIVED AFTER 09/25/89 WILL APPEAR ON NEXT STATEMENT

NOTICE: SEE REVERSE FOR IMPORTANT INFORMATION

NAME ▶ [redacted]
ACCT NUMBER ▶

DOCTOR LEGEND: 7470 KENNETH R MARAVILLA MD

WILL BILL YOUR BLUE SHIELD
SURANCE, IF YOU HAVE PROVIDED US WITH
E INFORMATION.

UNIVERSITY PHYSICIANS
4545 15th Ave. N.E., Suite 400 — P.O. Box 50395
SEATTLE, WASHINGTON 98145-5065
TAX I.D. NO. 91-1220842 (206) 543-3600

CURRENT	31-60 DAYS	61-90 DAYS	91-120 DAYS	121-150 DAYS	OVER 150 DAYS	BALANCE DUE
249.00						249.00

Children's

Seattle, Washington 98105
(206) 526-2000

[redacted]

09/0[illegible]
CA
L99865

NAME: [redacted]
BIRTHDATE
ADDRESS:

RATE:

PATIENT WT:

Rx [redacted]

OR _____
PRINT FULL NAME

OR _____ OR _____
MAY SUBSTITUTE OR DISPENSE AS WRITTEN

DATE 07/23/99

REFILLS
NONE ☐
1 2 3 4 5
PRN _____ MONTHS

R: No: 254736 Date: 9/28/99
[redacted]
Drug: HALOPERIDOL 1MG/TAB.
Qty: 90EA
Doctor: WEY
Price: $9.80

44093 (1988)

4800 Sand Point Way N.E. Children's Hospital & Medical Center Seattle, Washington 98105
(206) 526-2000

PATIENT ID: [redacted]
NAME:
BIRTHDATE:
ADDRESS:
RATE:

CA
L99845

PATIENT WT: / K DRUG ALLERGIES:

Rx [redacted]

DR WCH
PRINT FULL NAME DEA NO.

DR
MAY SUBSTITUTE OR DR DISPENSE AS WRITTEN

DATE 9/28/99

REFILLS
NONE ☐
1 2 3 4 5
PRN MONTHS

Rx No: 244727 Date: 9/28/99
Name: [redacted]
Drug: DIPHENHYDRAMINE 25MG/CAP.
Qty: 6=EA
Doctor: WCH
Price: $7.70

44093 (1988)

CONF019533

ST. FRANCIS COMMUNITY HOSPITAL
OF FEDERAL WAY

34515 NINTH AVE SOUTH
FEDERAL WAY, WASHINGTON 98003

PHONE 952-7966

24-HOUR PHARMACY
TAX ID #91-[redacted]

FOR: [redacted] DATE: [illegible]

Rx NUMBER	MEDICATION	COST
003879	Haldol 1mg #10	8.65
	TOTAL	8.65

PHARMACIST SIGNATURE [redacted]

7170-035 2/88

CONF019534

Fred Meyer PRESCRIPTIONS
25250 Pacific Hwy So
Kent, WA 98031

PH. 941-2905

Use Before 09/90

MY 619945 Dr. GRABER, JAME

[redacted]

KENT WA 98032
*** YOU'LL FIND IT AT **
*** FREDDY'S ***
LORAZEPAM RU
1MG 50 TABS

PRICE $15.19 PAY $15.19
ORIG 09/08/89
PREV [redacted] NOW 09/08/89

Save this receipt for Tax and Insurance.

STAPLE IN THIS AREA

[redacted]

PO BOX 9249
OLYMPIA WA [redacted] 98504

MEDICARE (MEDICARE NO.)	MEDICAID (MEDICAID NO.)	CHAMPUS (SPONSOR'S SSN)	CHAMPVA (VA FILE NO.)	FECA BLACK LUNG (SSN)	OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
[redacted]

2 PATIENT'S DATE OF BIRTH
[redacted]

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 98032

TELEPHONE NO [redacted]

5 PATIENT'S SEX
MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)
AMERICAN TRANSPORT

7 PATIENT'S RELATIONSHIP TO INSURED
SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT
YES [ ] [X] NO
B. ACCIDENT
AUTO [ ] [X] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 98
TELEPHONE NO

11a CHAMPUS SPONSOR'S
STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED
BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
SIGNED
DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98105

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] NO [ ] CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3, ETC. OR 0x CODE
1. 780.1
2.
3.
4.

B
EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * TOS	H LEAVE BLANK
09/09/89		IH	90240	1 DAYS SUBSEQ HOSP CARE W 98	780.1	42 00	01 DAYS		
09/07/89		IH	90200	INIT HOSP CARE BRIEF EXAM	780.1	77 00			

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
3700
3800
DATE 101189

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27 TOTAL CHARGE 119 00

28 AMOUNT PAID

29 BALANCE DUE 119

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME ADDRESS ZIP CODE AND TELEPHONE NO
FARROW, JAMES A MD
COHMC ASSOC. CLINICIANS
[redacted]
NO SEATTLE, WA 98105
PHONE: [redacted]

32 YOUR PATIENT'S ACCOUNT NO [redacted]

33 YOUR EMPLOYER I.C. NO [redacted]

* PLACE OF SERVICE AND TYPE OF SERVICE (TOS) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/83

Form HCFA-1500 (1-84) (C-2)
Form CHAMPUS-501
Form OWCP-
Form RRB-

CONF019536

THIS AREA

[redacted]

OLYMPIA WA 98504

[redacted]

MEDICARE (MEDICARE NO.)	MEDICAID (MEDICAID NO.)	CHAMPUS (SPONSOR'S SSN)	CHAMPVA (VA FILE NO.)	FECA BLACK LUNG (SSN)	OTHER (CERTIFICATE SSN)	

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): [redacted]

2. PATIENT'S DATE OF BIRTH: [redacted]

3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL):

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): [redacted]
KENT, WA 98032

5. PATIENT'S SEX: MALE [X] FEMALE [ ]

6. INSURED'S I.D. NO. FOR PROGRAM CHECKED ABOVE (INCLUDE ALL LETTERS): - -

7. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

TELEPHONE NO: [redacted]

[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT: YES [ ] [X] NO
B. ACCIDENT: AUTO [ ] [X] OTHER

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): [redacted]
KENT, WA 980[illegible]

TELEPHONE NO:

11a. CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE:

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING): I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED: DATE:

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED (INSURED OR AUTHORIZED PERSON):

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP):

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION:

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES:

16a. IF EMERGENCY CHECK HERE [ ]

17. DATE PATIENT ABLE TO RETURN TO WORK:

18. DATES OF TOTAL DISABILITY: FROM THROUGH

DATES OF PARTIAL DISABILITY: FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY):

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): [redacted] SEATTLE, WA 98105

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES:

23. A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, ETC. OR 0x CODE)

1. 170.1
2.
3.
4.

8. EPSDT: YES [ ] NO [ ]
FAMILY PLANNING: YES [ ] NO [ ]

PRIOR AUTHORIZATION NO:

24. A DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. TOS	H. LEAVE BLANK
09/20/89		0	09310	CONSULTATION	170.1	4000			*

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF): 3600

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK): YES [X] NO [ ]

27. TOTAL CHARGE: 4000

28. AMOUNT PAID:

29. BALANCE DUE: 40.00

30. YOUR SOCIAL SECURITY NO:

31. PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO:
SHELLER, BARBARA DDS
COHMC ASSOC. CLINICIANS
[redacted]
NO SEATTLE, WA 98105
PHONE: [redacted]

DATE: 101189

32. YOUR PATIENT'S ACCOUNT NO: [redacted]

33. YOUR EMPLOYER I.D. NO: [redacted]

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/84

Form HCFA-1500 (1-84) (C:2)
Form CHAMPUS-501

Form OWCP-1500
Form RRB-1500

CONF019537

STAPLE IN THIS AREA

[redacted]

PO BOX 9248
OLYMPIA WA [redacted] 98504

[ ] MEDICARE (MEDICARE NO.)	[ ] MEDICAID (MEDICAID NO.)	[ ] CHAMPUS (SPONSOR'S SSN)	[ ] CHAMPVA (VA FILE NO.)	[ ] FECA BLACK LUNG (SSN)	[ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
[redacted]

2 PATIENT'S DATE OF BIRTH
[redacted]

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 98032

5 PATIENT'S SEX
MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS)
- -

7 PATIENT'S RELATIONSHIP TO INSURED
SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

TELEPHONE NO. [redacted]

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO:
A PATIENT'S EMPLOYMENT
YES [ ] [X] NO
B ACCIDENT
AUTO [ ] [X] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 9803[illegible]
TELEPHONE NO.

11a CHAMPUS SPONSOR'S
STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED
BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
SIGNED [redacted] DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (INSURED OR AUTHORIZED PERSON) [redacted]

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE DATES

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98105

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] NO [ ] CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3, ETC. OR DX CODE
1 521.0
2
3
4

B
EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * TOS	H LEAVE BLANK
09/21/89		0	09310	CONSULTATION	521.0	4000			*

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
3500

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27 TOTAL CHARGE 4000

28 AMOUNT PAID

29 BALANCE DUE 40.0

30 YOUR SOCIAL SECURITY NO.

31 PHYSICIAN'S, SUPPLIER'S, AND [illegible] GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
OMNELL, LENA DDS
COHMC ASSOC. CLINICIANS
[redacted]
NO SEATTLE, WA 98105
PHONE: [redacted]

DATE 101189

32 YOUR PATIENT'S ACCOUNT NO. [redacted]

33 YOUR EMPLOYER I.D. NO. [redacted]

* PLACE OF SERVICE AND TYPE OF SERVICE (TOS) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/89

Form HCFA-1500 (1-84) (C-2)
Form OWCP-1500

CONF019538

STAPLE IN THIS AREA

[redacted]

PO BOX 9748
OLYMPIA WA 98504

MEDICARE (MEDICARE NO.)	MEDICAID (MEDICAID NO.)	CHAMPUS (SPONSOR'S SSN)	CHAMPVA (VA FILE NO.)	FECA BLACK LUNG (SSN)	OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
[redacted]

2. PATIENT'S DATE OF BIRTH
[redacted]

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 [redacted]
KENT, WA 98032

5 PATIENT'S SEX
MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
AMERICAN TRANSPORT

7 PATIENT'S RELATIONSHIP TO INSURED
SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

TELEPHONE NO. [redacted]

9 OTHER HEALTH INSURANCE [redacted] POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT
YES [ ] [X] NO
B. ACCIDENT
AUTO [ ] [X] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 9803

TELEPHONE NO.

11a CHAMPUS SPONSOR'S
STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED
BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (eg. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98125

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] NO [ ] CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE (1, 2, ETC. OR DX CODE)
1 298.9
2
3
4

B
EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G E.P.S.D.T.	H LEAVE BLANK
09/20/89		IH	90830 01	NEURODIAG EVAL-WESCHLER	298.9	9500			
09/20/89		IH	90830 40	NEURODIAG-SELECTIVE REMINDING	298.9	2400			
09/20/89		IH	90830 39	NEURODIAG-SENSORY PERCEPT/EXAM	298.9	7200			
09/20/89		IH	90830 37	NEURODI/TST/APHASIA/SCREEN	298.9	4750			
09/20/89		IH	90830 26	NEURODIAG EVAL TST-CATEGO/9-14	298.9	7200			
09/25/89		IH	90887 20	INTERMED CONSULT EVALUATION	298.9	9500			

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
2800 2300
2400
2500
2600
2700
DATE 101189

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27 TOTAL CHARGE 40550

28 AMOUNT PAID

29 BALANCE DUE 405.50

30 YOUR SOCIAL SECURITY NO.

31 PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
FAY, GAYLE PHD
COHMC ASSOC. CLINICIANS
[redacted]
SEATTLE, WA 98105
PHONE: [redacted]

32 YOUR PATIENT'S ACCOUNT NO.
[redacted]

33 YOUR EMPLOYER I.D. NO.
[redacted]

(TOS) CODES ON THE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) (C-2)
Form CHAMPUS-501

Form OWCP-1500
Form RRB-1500

CONF019539

STAPLE IN THIS AREA

[redacted]

PO BOX 9248
OLYMPIA WA [redacted] 98504

MEDICARE (MEDICARE NO.)	MEDICAID (MEDICAID NO.)	CHAMPUS (SPONSOR'S SS#)	CHAMPVA (VA FILE NO.)	FECA BLACK LUNG (SS#)	OTHER (CERTIFICATE SS#)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): [redacted]

2. PATIENT'S DATE OF BIRTH: [redacted]

4. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL):

[redacted]
KENT, WA 98032

5. PATIENT'S SEX: MALE [X] FEMALE [ ]

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS):
AMERICAN TRANSPORT

7. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

TELEPHONE NO. 839-5714

[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
B. ACCIDENT: AUTO [ ] OTHER [X]

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE):
[redacted]
KENT, WA 980[illegible]
TELEPHONE NO.

11a. CHAMPUS SPONSOR'S
STATUS: ACTIVE DUTY [ ] DECEASED [ ] RETIRED [ ] BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
SIGNED

DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:

15. ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

16. DATE FIRST CONSULTED YOU FOR THIS CONDITION

17. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE DATES

17a. IF EMERGENCY CHECK HERE [ ]

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY: FROM THROUGH

DATES OF PARTIAL DISABILITY: FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98105

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] NO [ ] CHARGES

23. A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3, ETC. OR DX CODE
1. 298.9
2.
3.
4.

B. EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. TOS	H. LEAVE BLANK
09/20/89		IH	90830 35	NEURODIAG TEST-RHYTH M	298.9	7200			
09/20/89		IH	90830 34	NEURODIAG-SPEECH SCU NDS PERCE	298.9	7200			
09/20/89		IH	90830 29	NEURODIAG-TEST TRAIL S A&B	298.9	7200			
09/20/89		IH	90830 28	NEURODIA-TACTUAL PEF ORM/TEST	298.9	7200			
09/25/89		IH	90887 22	INTERMED CONSULT EVA LUATION	298.9	9500			
09/25/89		IH	90825 40	NEURODIAG TEST ANALY SIS/COMPR	298.9	19000			

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR CREDENTIALS (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)
3400 2900
3000
3100
3200
3300
DATE 121189

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27. TOTAL CHARGE 53300

28. AMOUNT PAID

29. BALANCE DUE 533.00

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
FAY, GAYLE PHD
COHMC ASSOC. CLINICIANS
[redacted]
SEATTLE, WA 98105
PHONE: [redacted]

32. YOUR PATIENT'S ACCOUNT NO.
[redacted]

33. YOUR EMPLOYER I.D. NO.
[redacted]

* PLACE OF SERVICE AND TYPE OF SERVICE (TOS) CODES ON THE BACK REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE

HCFA-1500 (1-84) (C-2) CHAMPUS 501

Form OWCP-1500
Form RRB-1500

CONF019540

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

OFFICE OF PROVIDER SERVICES

[redacted]

OLYMPIA WA [redacted] 98504

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
[redacted]

2 PATIENT'S DATE OF BIRTH
[redacted]

3 INSURED'S NAME (LAST NAME FIRST NAME MIDDLE INITIAL)

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 98032

TELEPHONE NO [redacted]

5 PATIENT'S SEX
MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS)
AMERICAN TRANSPORT

7 PATIENT'S RELATIONSHIP TO INSURED
SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO
A PATIENT'S EMPLOYMENT
YES [ ] [X] NO
B ACCIDENT
AUTO [ ] [X] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 980
TELEPHONE NO

11a CHAMPUS SPONSOR'S
STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED
BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
SIGNED [redacted] DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE DATES

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98105

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] NO [ ] CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE (1, 2, 3, ETC. OR 0) CODE
1 780.1
2
3
4

B
EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G EMG	H LEAVE BLANK
09/23/89		IH	90250	2 DAYS HOSP VISIT/ EXAM LIMIT	780.1	10600	02 DAYS		

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
5200
DATE 101189

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27 TOTAL CHARGE 10600

28 AMOUNT PAID

29 BALANCE DUE 106.0

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S SUPPLIER'S AND GROUP NAME ADDRESS ZIP CODE AND TELEPHONE NO
REICHLER, ROBERT MD
COHMC ASSOC. CLINICIANS
[redacted]
SEATTLE, WA 98105
PHONE: [redacted]

32 YOUR PATIENT'S ACCOUNT NO [redacted]

33 YOUR EMPLOYER I.D. NO [redacted]

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/87

HCFA-150[illegible]-2) S01

Form OWCP-1500
Form RRB-1500

CONF019541

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

(OFFICE OF PROVIDER SERVICES
PO BOX 9248
OLYMPIA WA [redacted] 98504

MEDICARE (MEDICARE NO.)	MEDICAID (MEDICAID NO.)	CHAMPUS (SPONSOR'S SSN)	CHAMPVA (VA FILE NO.)	FECA BLACK LUNG (SSN)	OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
[redacted]C

2 PATIENT'S DATE OF BIRTH
[redacted]

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 PA[redacted]
KENT, WA 98032

5 PATIENT'S SEX
MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)
- -
AMERICAN TRANSPORT

7 PATIENT'S RELATIONSHIP TO INSURED
SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

TELEPHONE NO [redacted]

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO
A PATIENT'S EMPLOYMENT
YES [ ] [X] NO

B. ACCIDENT
AUTO [ ] [X] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 980

TELEPHONE NO

11a CHAMPUS SPONSOR'S
STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED
BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED

DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF

ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98105

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] [ ] NO CHARGES

23 [illegible] TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3,
ETC. OR DX CODE
1 780.1
2
3
4

8
EPSDT YES [ ] [ ] NO
FAMILY PLANNING YES [ ] [ ] NO

PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G EPSDT	H LEAVE BLANK
09/21/89		IH	90853	GROUP THERAPY	780.1	4500			
09/19/89		IH	90853	GROUP THERAPY	780.1	4500			
09/18/89		IH	90847	FAMILY THERAPY	780.1	10600			
09/22/89		IH	90843	PSYCHOTHERAPY	780.1	5300			
09/21/89		IH	90843	PSYCHOTHERAPY	780.1	5300			
09/20/89		IH	90843	PSYCHOTHERAPY	780.1	5300			

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

4700 3900
4000
4100
4500
4600

DATE 101189

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27 TOTAL CHARGE 35500

28 AMOUNT PAID

29 BALANCE DUE 355.0

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO
CALLNER, DALE A PHD
[redacted]ICIANS
[redacted]
SEATTLE, WA 98105
PHONE: [redacted]

32 YOUR PATIENT'S ACCOUNT NO
[redacted]

33 YOUR EMPLOYER I.D. NO
[redacted]

[redacted] (TOTAL) [illegible] ON THE BACK

APPROVED BY AMA [illegible]
OMB [illegible] SERVICE [illegible]3

Form HCFA-1500 (1-84) (C-2)
Form CHAMPUS-501

Form OWCP-1500
Form RRB-1500

CONF019542

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

OFFICE OF PROVIDER SERVICES
PO BOX 9248
OLYMPIA W[redacted] 98504

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
[redacted]

2 PATIENT'S DATE OF BIRTH
4 | 02 | 75

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 PAT[redacted]
KENT, WA 98032

5 PATIENT'S SEX
MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)
AMERICAN TRANSPORT

TELEPHONE NO [redacted]

7 PATIENT'S RELATIONSHIP TO INSURED
SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

9 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOY HEALTH PLAN

9 OTHER HEALTH INSURANC[redacted] OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO
A PATIENT'S EMPLOYMENT
YES [ ] [X] NO

B ACCIDENT
AUTO [ ] [X] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 9

TELEPHONE NO

11a CHAMPUS SPONSOR'S
STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED
BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98105

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] [ ] NO CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE (1, 2, 3, ETC. OR DX CODE)
1 780.1
2
3
4

B
EPSDT YES [ ] [ ] NO
FAMILY PLANNING YES [ ] [ ] NO

PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G EMG	H LEAVE BLANK
09/19/89		IH	90841	PSYCHOTHERAPY	780.1	3300			
09/18/89		IH	90841	PSYCHOTHERAPY	780.1	3300			
09/21/89		IH	90280	HOSP VISIT/EXAM COMP RE SERV	780.1	13700	01 DAYS		

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
4800
4900
5000

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27 TOTAL CHARGE 20300

28 AMOUNT PAID

29 BALANCE DU 203

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME ADDRESS ZIP CODE AND TELEPHONE NO
CALLNER, DALE A PHD
COHMC ASSOC. CLINICIANS
[redacted]
10 NO SEATTLE, WA 98105
PHONE: [redacted]

DATE 101189

32 YOUR PATIENT'S ACCOUNT NO [redacted]

33 YOUR EMPLOYER ID NO [redacted]

32a PLACE OF SERVICE AND NUMBER OF SERVICE (TOS) CODES ON THE BACK

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/87

Form HCFA-1500 (1-84) (C...)
Form CHAMPUS-501

FORM OWCP...
FORM RRB...

CONF019543

1. PLEASE WRITE ONLY ONE RX PER BLANK

Children's Hospital & Medical Center Clinics

4800 Sand Point Way N.E. Seattle, Washington 98105 (206) 526-2000

PATIENT ID: [redacted]

NAME: [redacted]

BIRTHDATE:

CITY: CH-275

STREET: [redacted]

PATIENT

℞ Haloperidol 1mg tabs

Dispense # 120

Dose # g HS

PAID

DR Alan S. Unis, M.D. DEA NO.

PRINT FULL NAME

DR [signature] MD

MAY SUBSTITUTE OR DR DISPENSE AS WRITTEN

DATE 10/20/89

REFILLS

NONE ☐

1 (2) 3 4 5

PRN MONTHS

** CHILDRENS PHARMACY RECEIPT **
Rx No: 266336 Date: 10/20/89
Name: [redacted]
Drug: HALOPERIDOL 1MG/TAB.
Qty: 120EA
Doctor: UNIS
Price: $11.80

44166 (1988)

[redacted]

NOTICE TO THE PATIENT

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

SECTION A

PATIENT NAME

09 15 89

SOCIAL SECURITY NO | GRO[redacted]O OR PLAN I D | EMPLOYER NAME [redacted]

297 TRANSACTIONS AFTER THIS CLOSING DATE WILL APPEAR ON YOUR NEXT STATEMENT

JOB CONNECTED ILLNESS/INJURY | IF AUTO ACCIDENT GIVE DATE | INSURANCE CO. LIST 2ND INS. ON BACK

ACCOUNT NO
34 0774438

DOCTOR OR PRACTICE NAME

ORAL MEDICINE PRACTITIONERS &
UNIVERSITY DENTISTS
SC-62 U/W ROOM D221
SEATTLE WA 98195

PATIENT/INSURED

[redacted]
KENT WA 98032

IMPORTANT: SEE INSTRUCTIONS ON BACK TO FILE CLAIM

TAX I.D. NUMBER	DOCTOR OR PRACTICE NAME	DATE SERVICE	PREVIOUS BALANCE
DR [redacted]	ORAL MEDICINE PRACTITIONERS 1989ADA		.00

NO	PATIENT	TOOTH NUMBER	SURFACE	DESCRIPTION OF TRANSACTIONS	MO DAY	CODE	MOD	PAYMENTS / CHARGES AMOUNT
34	[redacted]		528.98	GROSS MICRO TISSUE E082988304				40.00

[redacted]

CHILDREN'S ASSOCIATED CLI[redacted]IANS
4545-15th Ave N.E., Suite 201
P.O. Box C-[redacted]2010
Seattle, Washington 98105-1010 • Phone (206) 633-4500
TAX ID NO 91-1162991

STATEMENT

PAGE ► 1

TMT DATE		PRIMARY	SECOND-ARY	I/O	PATIENT NAME(S) / ACCOUNT NUMBERS	GUARANTOR NUMBER
2/18/89		800	001	I	[redacted]	96872
		800	001	O		

ENTERED AFTER 10/16/89
WITH THIS STATEMENT

[redacted]
KENT, WA 98032

MAKE CHECKS PAYABLE TO: CHMC ASSOCIATED CLINICIANS
VISA / MASTERCARD ACCEPTED

IMPORTANT

Payment of these charges is your responsibility. This bill is for Physician Services/Clinic Services at CHMC. Charges appearing on this statement are not included on any Hospital bill or statement. Payment of the balance shown is due and payable within 30 days unless prior payment terms have been arranged. See reverse side for more information.

FOR PROPER CREDIT PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

CODE	MOD	PL	SERVICE DATE	ICD 9	DR #	DESCRIPTION	AMOUNT
						PREVIOUS BALANCE	2,636.00
CASH			09/19/89			PAYMENT RECEIVED FROM YOUR INS	63.75-
ADJ.			09/19/89			KCM CONTRACT ALLOWANCE - OCM	148.25-
CASH			09/22/89			PAYMENT RECEIVED FROM YOUR INS	629.00-
ADJ.			09/22/89			KCM CONTRACT ALLOWANCE - OCM	307.00-
CASH			10/05/89			PAYMENT RECEIVED FROM YOUR INS	159.85-
ADJ.			10/05/89			KCM CONTRACT ALLOWANCE - OCM	66.00-
				0385665		[redacted]	
						DENTAL	
09310		O	09/20/89	170.1	8559	CONSULTATION	40.00
09310		O	09/21/89	521.0	8621	CONSULTATION	40.00
						NEURODIAGNOSTIC: INPATIENT	
90830	29	I	09/20/89	298.9	8259	NEURODIAG-TEST TRAILS A&B	32.00
90830	26	I	09/20/89	298.9	8259	NEURODIAG EVAL TST-CATEGO/9-14	72.00
90830	28	I	09/20/89	298.9	8259	NEURODIA-TACTUAL PERFORM/TEST	72.00

RETAIN THIS STATEMENT FOR TAX PURPOSES

ENTERED AFTER 10/16/89 WILL APPEAR ON NEXT STATEMENT

NOTICE. SEE REVERSE FOR IMPORTANT INFORMATION

REFERRING DOCTOR NAME ► [redacted]
REFERRING DOCTOR NUMBER ►
DO NOT

INSURANCE SUBSCRIBERS
YOUR INSURANCE WILL BE BILLED IF WE HAVE RECEIVED THE INSURANCE INFORMATION AND/OR YOUR CLAIM FORMS. WE WILL CONTACT YOU IF ADDITIONAL INFORMATION IS REQUIRED. YOU WILL RECEIVE A STATEMENT UNTIL THE BALANCE IS PAID BY YOU OR BY YOUR INSURANCE CARRIER.

CHILDREN'S ASSOCIATED CLINICIANS
4545 15TH N.E., SUITE 201
P.O. BOX C-50010
SEATTLE, WASHINGTON 98105-1010
TAX I.D.#: 91-1162991

BALANCE DUE
SEE NEXT PAGE

CONF019547

[redacted]

STATEMENT

PAGE ►

STMT. DATE		PRIMARY	SECONDARY	I/O	PATIENT NAME(S) / ACCOUNT NUMBERS	GUARANTOR NUMBE
10/18/89		800	001	I	[redacted]	96872
		800	001	O		

PAYMENTS RECEIVED AFTER 10/16/89
WILL APPEAR ON NEXT MONTH'S STATEMENT

[redacted]
KENT, WA
98032

MAKE CHECKS PAYABLE TO: CHMC ASSOCIATED CLINICIANS
VISA / MASTERCARD ACCEPTED

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FOR PROPER CREDIT PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

CPT CODE	MOD	PL	SERVICE DATE	ICD-9	DR	DESCRIPTION	AMOUNT
90830	35	I	09/20/89	298.9	8259	NEURODIAG TEST-RHYTHM	72.0
90830	37	I	09/20/89	298.9	8259	NEURODI/TST/APHASIA/SCREEN	47.0
90830	01	I	09/20/89	298.9	8259	NEURODIAG EVAL-WESCHLER	95.0
90830	34	I	09/20/89	298.9	8259	NEURODIAG-SPEECH SOUNDS PERCE	72.0
90830	40	I	09/20/89	298.9	8259	NEURODIAG-SELECTIVE REMINDING	24.0
90830	39	I	09/20/89	298.9	8259	NEURODIAG-SENSORY PERCEPT/EXAM	72.0
90887	20	I	09/25/89	298.9	8259	INTERMED CONSULT EVALUATION	95.0
90825	40	I	09/25/89	298.9	8259	NEURODIAG TEST ANALYSIS/COMPR	190.0
90887	20	I	09/25/89	298.9	8259	INTERMED CONSULT EVALUATION	95.0
						INPATIENT MEDICINE	
90200		I	09/07/89	780.1	1866	INIT HOSP CARE BRIEF EXAM	77.0
90240		I	09/08/89	780.1	1866	1 DAYS SUBSEQ HOSP CARE W BR	42.0
						BEHAVIORAL SCIENCE	
90220		I	09/07/89	780.1	8662	COMPREHENSIVE INITIAL EXAM	168.0
90801		I	09/07/89	780.1	8662	DIAGNOSTIC INTERVIEW/WORK-UP	99.0
90250		I	09/09/89	780.1	8662	2 DAYS HOSP VISIT/EXAM LIMIT	106.0
90841		I	09/18/89	780.1	8549	PSYCHOTHERAPY	33.0
90847		I	09/18/89	780.1	8549	FAMILY THERAPY	106.0
90853		I	09/19/89	780.1	8549	GROUP THERAPY	45.0
90841		I	09/19/89	780.1	8549	PSYCHOTHERAPY	33.0
90280		I	09/19/89	780.1	8662	HOSP VISIT/EXAM COMPRE SERV	137.0
90843		I	09/20/89	780.1	8549	PSYCHOTHERAPY	53.0

RETAIN THIS STATEMENT FOR TAX PURPOSES

PAYMENTS RECEIVED AFTER 10/16/89 WILL APPEAR ON NEXT STATEMENT

NOTICE: SEE REVERSE FOR IMPORTANT INFORMATION

GUARANTOR NAME ►
GUARANTOR NUMBER ► [redacted]
ACCT. 88

INSURANCE SUBSCRIBERS
OUR INSURANCE WILL BE BILLED IF WE HAVE RECEIVED THE INSURANCE INFORMATION AND OR YOUR CLAIM-FORMS. WE WILL CONTACT YOU IF ADDITIONAL INFORMATION IS REQUIRED. YOU WILL RECEIVE A STATEMENT UNTIL THE BALANCE IS PAID BY YOU OR BY YOUR INSURANCE CARRIER.

CHILDREN'S ASSOCIATED CLINICIANS
4545 15TH N.E., SUITE 201
P.O. BOX C-50010
SEATTLE, WASHINGTON 98105-1010
TAX ID.# 91-1162991

						BALANCE DU
						SEE NEXT PAGE

CHILDREN'S ASSOCIATED CLINICIANS
4545 15th Ave N.E., Suite 201
P.O. Box C-50010
Seattle, Washington 98105-1010 • Phone (206) 633-4500
TAX ID NO 91-1162991

STATEMENT

PAGE ►

STMT DATE		PRIMARY	SECONDARY	I/O	PATIENT NAME(S) / ACCOUNT NUMBERS	GUARANTOR NUMBE
		800	001	I	[redacted]	
10/18/89		800	001	O		96872

PAYMENT RECEIVED AFTER 10/16/89 WILL APPEAR ON NEXT MONTH'S STATEMENT

[redacted]
KENT, WA 98032

MAKE CHECKS PAYABLE TO: CHMC ASSOCIATED CLINICIANS
VISA / MASTERCARD ACCEPTED

IMPORTANT

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FOR PROPER CREDIT PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

CPT CODE	MOD	PL	SERVICE DATE	ICD 9	DR	DESCRIPTION	AMOUNT
90853		I	09/21/89	780.1	8549	GROUP THERAPY	45.
90780		I	09/21/89	780.1	8549	HOSP VISIT/EXAM COMPRE SERV	137.
90843		I	09/21/89	780.1	8549	PSYCHOTHERAPY	53.
90843		I	09/22/89	780.1	8549	PSYCHOTHERAPY	53.
90250		I	09/23/89	780.1	8086	2 DAYS HOSP VISIT/EXAM LIMIT	106.

RETAIN THIS STATEMENT FOR TAX PURPOSES

PAYMENT RECEIVED AFTER 10/16/89 WILL APPEAR ON NEXT STATEMENT

NOTICE SEE REVERSE FOR IMPORTANT INFORMATION

PATIENT NAME ►
PATIENT NUMBER ► [redacted]
DOB

INSURANCE SUBSCRIBERS
YOUR INSURANCE WILL BE BILLED IF WE HAVE RECEIVED THE INSURANCE INFORMATION AND/OR YOUR CLAIM-FORMS WE WILL CONTACT YOU IF ADDITIONAL INFORMATION IS REQUIRED YOU WILL RECEIVE A STATEMENT UNTIL THE BALANCE IS PAID BY YOU OR BY YOUR INSURANCE CARRIER.

CHILDREN'S ASSOCIATED CLINICIANS
4545 15TH N.E., SUITE 201
PO BOX C-50010
SEATTLE, WASHINGTON 98105-1010
TAX ID # 91-1162991

						BALANCED
						3,573.

CONF019549

REVISED 1/89

Agribusiness
American Business
America Cultures
erica Heritage
rican Labor
nimal Science
Archery
Architecture
Art
Astronomy
Athletics
Atomic Energy
Aviation
Backpacking
Basketry
Beekeeping
Bird Study
Botany
Bugling
Camping
Canoeing
Chemistry
Citizenship-Community
Citizenship-Nation
Citizenship-World
Coin Collecting
Communications
Computers
nsumer Buying
king
Cycling
Dentistry
Dog Care
Drafting
Electricity
Electronics
Emergency Preparedness
Energy
Engineering
Environmental Science
Farm Mechanics
Fingerprinting
Firemanship
First Aid
Fish & Wildlife Mgmt
Fishing
Forestry
Gardening
Geneology
General Science
Geology
Golf
Graphic Arts
Handicapped Awareness
Hiking
Home repairs
Horsemanship
Indian Lore
Insect Life
Journalism
Landscape Architect
Law
Leatherworking
Lifesaving
Machinery
Mammals
Masonry
Metals Engineering
Metalwork
Model Design & Bldg
Motorboating
Music
Nature
Oceanography
Orienteering
Painting
Personnal Fitness
Personal Management
Pets
Photography
Pioneering
Plant Science
Plumbing
Pottery
Public Health
Public Speaking
Pulp and Paper
Rabbit Raising
Radio
Railroading
Reading
Reptile Study
Rifle Shooting
Rowing
Safety
Salesmanship
Scholarship
Sculpture
Shotgun Shooting
Signaling
Skating
Skiing
Small-Boat Sailing
Soil & Water Conserv
Space Exploration
Sports
Stamp Collecting
Surveying
Swimming
Textile
Theater
Traffic Safety
Truck Transportation
Veterinary Science
Water Skiing
Weather
Whitewater
Wilderness Survival
Wood Carving
Woodwork

[redacted]

PHONE #

CITY ZIP

NOTE: MERIT BADGE COUNSELORS SHALL BE REGISTERED
Based on the requirements contained in the pamphlet for this Merit Badge, I provide the following as my qualifications for being a counselor for this award (use back if necessary). Include reason(s) why you would like to be a counselor for this badge.

CERTIFICATION: PLEASE NOTE: UNIT No. 455 DISTRICT Lenape

I have read the current edition of the pamphlet for these Merit Badges and understand all requirements for earning the awards.

2/11/90
Signature of District Advancement Chairman

Signature of Applicant

Date

MERIT BADGES I WILL COUNSEL ARE:

1. Emergency Preparedness
2. First Aid
3. Golf
4. Hiking
5. Science

(USE BACK OF PAGE IF NECESSARY) DISTRICT ONLY ✓ TROOP ONLY ___ ALL SCOUTS ___

CONF019550

AMP STAFF AGREEMENT

The following documents must be presented to the Camp Director before this agreement can be signed.

Camp Staff Application

Valid Medical Form

IRS W-4 Form

Department of Immigration & Naturalization Form

Uniform Order Form

Proof of Certification (i.e. NCS, CPR, Food Handlers Permit, 1st Aid Training, etc.) —

I am a currently registered member of the Boy Scouts of America and as a member of the Camp Staff, agree to live in accordance with the Scout Oath and Law at all times.

NAME Edgar Tisdale POSITION Health & Safety

ACCEPTED [redacted] (Signature) DATE 6 June 89

PARENTAL APPROVAL (if under 18 years of age) _____

PERMANENT HOME ADDRESS [redacted]

PHONE NUMBER [redacted] SOCIAL SECURITY [redacted]

IN CASE OF EMERGENCY - CONTACT [redacted]

RELATIONSHIP Wife PHONE # [redacted] (Home) (Work)

ACCEPTING FOR THE COUNCIL Jerry Parker
1989 Camp Director

DATE 6/6/89

JT:blm
6/28/88
2 /2/5-7 5/5/89 pek

BOY SCOUTS OF AMERICA

ADULT APPLICATION

UNIT SCOUTERS	
Check one	
Pack No.	
Troop No.	
Team No.	
Post No.	
Ship No.	

OR

COUNCIL/DISTRICT SCOUTERS
Council/District position
District name

Please print one letter in each space—press hard; you are making four copies.

First name and initial: EDGAR A
Last name: TISDALE
Social Security number (optional): [redacted]

Address—street or R.F.D.: [redacted]
Additional address information if necessary:

City: TACOMA State: WA ZIP code: 98[illegible]

Home phone: [redacted] Business phone: [redacted]

Date of birth: 1 22 53 (Month Day Year)
Training (see cover): G
Position Code (see cover): 42

Occupation, employer, and business address: Staff Specialist [illegible]

Years at this employment: 1
Boys' Life:
New leader:
Transfer:
Former leader: ✓
Sex: M
U.S. citizen: Yes ✓

Driver's license no. [redacted] State: [illegible] Expiration: 12/28/9[illegible]

1. Scouting background
Position / Council / Year
[illegible]
[illegible]

2. Experience working with youth in other organizations:
[illegible]

3. Previous residences (in last 5 years)
City / State
[illegible]

4. Current memberships (religious, community, business, labor, or professional organizations)

5. References (Please list those who are familiar with your character as it relates to working with youth. References will be checked when necessary.)
Name: Cloyd Gatnell
Name: Larry Asbill
Name: Fred Feller

6. Additional information
a. Do you use illegal drugs? Yes (No)
b. Have you ever been convicted of a crime or offense? If yes, explain below. Yes (No)
c. Have you ever been charged with child neglect or child abuse? Yes (No)
d. Has your driver's license ever been taken, suspended or revoked? If yes, explain below. Yes (No)
e. Other than the above, is there any fact or circumstance involving you or your background that would call into question your being entrusted with the supervision, guidance, and care of young people? If yes, explain below. Yes (No)

I understand that:
a. The information that I have provided may be verified if necessary, by contacting persons or organizations named in this application, or by contacting any person or organization that may give information concerning me. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to hold harmless the chartered organization, local council, Boy Scouts of America and their officers, employees, and volunteers thereof.
b. In signing this application, I affirm that the information I have given is true and correct.

X [signature] 1/2[illegible]
Signature of applicant Date

APPROVALS FOR UNIT SCOUTERS
To the best of our knowledge, this applicant meets the leadership standards of the Boy Scouts of America.

[signature]
Signature of unit committee chairman
Date

[signature]
Signature of chartered organization head or chartered organization representative
Date: [illegible]

Signature of Scout executive or designee
Date

APPROVAL FOR COUNCIL/DISTRICT SCOUTERS
To the best of my knowledge, this applicant meets the leadership standards of the Boy Scouts of America.

Signature of Scout executive or designee
Date

Registration fee $. Boys' Life fee $. Term (months) Unit renewal date (Month Year)

FOR COUNCIL USE
Transfer from: Council / No. / Unit No. / Member I.D. No.

Applicant has an unexpired membership certificate registration ... be accompanied by ... processing the transfer. Check if ... and attach certificate ... be returned to the council.

NATIONAL ... COPY

CONF019552

BOY SCOUTS OF AMERICA

ADULT APPLICATION

UNIT SCOUTERS
Check one
- ☐ Pack No. ____
- ☐ Troop No. ____
- ☐ Team No. ____
- ☐ Post No. ____
- ☐ Ship No. ____

OR

COUNCIL/DISTRICT SCOUTERS
Council/District position: UNIT COMMISSIONER
District name: LAKES

Please print one letter in each space—press hard; you are making four copies.

First name and initial: EDGAR A
Last name: TISDALE
Social Security number (optional): [redacted]

Address—street or R.F.D.: [redacted]
Additional address information (if necessary):
City: FT LEWIS
State: WA
ZIP code: 98433-9

Home phone: [redacted]
Business phone:
Date of birth: Month 12 Day 28 Year 53
Training: (see cover) B
Position Code: (see cover) 30

Occupation, employer, and business address
AMEDD C&A
MAMC
Fitzsimons Wash

Years at this employment: 13
Boys' Life: ☐
New leader:
Transfer: .
Former leader: X
Sex: M
U.S. citizen: Yes X

Driver's license No. [redacted] State Wash Expiration 12/28/90

505

1. Scouting background

Position	Council	Year
Committee Chm	Mount Rainier Council	1997-87
Scoutmaster	Mount Rainier Council	1986-87

2. Experience working with youth in other organizations?
Counselor Young Mens Program - LDS church

3. Previous residences (for last 5 years).

City	State
Spanaway	Wa
Freiburg	West Germany

4. Current memberships (religious, community, business, labor, or professional organizations).
Ft Lewis Ward Lakewood Stake, LDS Church

5. References. Please list those who are familiar with your character as it relates to working with youth. References will be checked when necessary.

Name Steven Smith
Name Cloyd Gutrell
Name Reid Marrell

6. Additional information.
a. Do you use illegal drugs? Yes (No)
b. Have you ever been convicted of a criminal offense? (If yes, explain below.) Yes (No)
c. Have you ever been charged with child neglect or abuse? Yes (No)
d. Has your driver's license ever been suspended or revoked? (If yes, explain below.) Yes (No)
e. Other than the above, is there any fact or circumstance involving you or your background that would call into question your being entrusted with the supervision, guidance, and care of young people? (If yes, explain below.) Yes (No)

I understand that:
a. The information that I have provided may be verified, if necessary, by contacting persons or organizations named in this application, or by contacting any person or organization that may have information concerning me. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to hold harmless the chartered organization, local council, Boy Scouts of America, and the officers, employees, and volunteers thereof.
b. In signing this application, I affirm that the information I have given is true and correct.

X Edgar A Tisdale — 7 March 89
Signature of applicant — date

APPROVALS FOR UNIT SCOUTERS
To the best of our knowledge, this applicant meets the leadership standards of the Boy Scouts of America:

Signature of unit committee chairman
Date

Signature of chartered organization head or chartered organization representative
Date

Signature of Scout executive or designee
Date

APPROVAL FOR COUNCIL/DISTRICT SCOUTERS
To the best of my knowledge, this applicant meets the leadership standards of the Boy Scouts of America:

JT

Signature of Scout executive or designee
Date 2/7/89

Registration fee $.
Boys' Life fee $.
Term (months) 1
Unit renewal date Month 01 Year 90

☐ If applicant has an unexpired membership certificate, registration may be accomplished by paying $1 for processing the transfer. Check the box and attach certificate. It will be returned by the council.

(Multiple)

FOR COUNCIL USE
Transfer from:
Council | Nat'l unit No. | Member ID No.

NATIONAL OFFICE COPY

CONF019553

6-28-90

NORM STONE, SE
TACOMA, WA.

CAMPER (11-12 YRS OLD) ILL AT CAMP
SENT TO MEDICAL - SENT HOME -
WENT TO HOSPITAL FOR 3 WEEKS
CAMPER INDICATED WAS MOLESTED
BY MEDICAL CAMP STAFF MBR.

EDGAR A. TISDALE
[redacted]
INFO TO COME

612 - D8604 - 058829
2/53

Added to IV file
Deleted from reg file
6/29/90

```
MS08                          MEMBERSHIP SUPPORT SYSTEM                    06/29/90
                                    MEMBER DELETE                          09:55:05
 CNCL 612  PRG/UNIT D8604 SEQ. 058829
 FIRST: EDGAR A                LAST : TISDALE
 ADDR1: [redacted]             ADDR2: TACOMA              WA
 ADDR3:                        ADDR4:                              ZIP: 98498
 REG STATUS: M  ENROLL: 0490 BIRTH: 1253 SEX: M  AGENCY: M ADULT/YOUTH: A
 POSITION:  42  FINDERCODE: 52  PHONE: [redacted]  BULK:    MAG-STATUS:
 REN DAT: 1290
 TRANSFER FROM = CNCL:      PGM/UNIT:       SEQ:        TRANSFER DATE:
                                    MAGAZINES
        --SOURCE--  PRICE SUB STRT --COPIES--  ISSUES TO GO AREAR  LAST LABEL EXP
   TYPE CNCL P/UNT  CODE  TRM DATE FIRST LAST  ORIG   TOTAL COUNT   PRINTED   DAT
    _   _____ _____   _    ___ _____           ___              ___
    _   _____ _____   _    ___ _____           ___              ___
    _   _____ _____   _    ___ _____           ___              ___
                          PF2>DELETE  PF12>MENU  CLR>END
MEMBER DELETED FROM DATABASE SUCCESSFULLY
```

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

[redacted] 98504

MEDICARE (MEDICARE NO.)	MEDICAID (MEDICAID NO.)	CHAMPUS (SPONSOR'S SSN)	CHAMPVA (VA FILE NO.)	FECA BLACK LUNG (SSN)	OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): [redacted]

2 PATIENT'S DATE OF BIRTH: [redacted]

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL):

4 [redacted]
KENT, WA 98032

TELEPHONE NO 839-5714

5 PATIENT'S SEX: MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
- -
AMERICAN TRANSPORT

7 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
B. ACCIDENT: AUTO [ ] OTHER [X]

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
[redacted]
KENT, WA 980
TELEPHONE NO

11a CHAMPUS SPONSOR'S
STATUS: ACTIVE DUTY [ ] RETIRED [ ] DECEASED [ ] BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
SIGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
[redacted] SEATTLE, WA 98105

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] NO [ ] CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE # 1, 2, 3, ETC. OR DX CODE
1 780.1
2
3
4

8
EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G TOS	H LEAVE BLANK
09/09/89		IH	90250	2 DAYS HOSP VISIT/ EXAM LIMIT	780.1	10600	02 DAYS		
09/07/89		IH	90801	DIAGNOSTIC INTERVIEW /WORK-UP	780.1	9900			
09/07/89		IH	90220	COMPREHENSIVE INITIA L EXAM	780.1	16800			
09/19/89		IH	90280	HOSP VISIT/EXAM COMP RF SERV	780.1	13700	01 DAYS		

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR CREDENTIALS: I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
4200
4300
4400
5100
DATE 101189

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES [X] NO [ ]

27 TOTAL CHARGE 51000

28 AMOUNT PAID

29 BALANCE DUE 510.0

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO
UNIS, ALAN MD
COHMC ASSOC CLINICIANS
[redacted]
SEATTLE, WA 98105
PHONE: [redacted]

32 YOUR PATIENT'S ACCOUNT NO [redacted]

33 YOUR EMPLOYER I.D. NO

f PLACE OF SERVICE AND TYPE OF SERVICE (TOS) CODES — BACK
REMARKS

APPROVED BY AMA COUNCIL

Form HCFA-1500 (1-84) (C 2) Form OWCP-1500

CONF019556